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CALIFORNIA COMMITTEE ON REGIONAL MEDICAL PROGRAMS

25 August 1972

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Dear Mr. Kerr:

This will acknowledge your letter of August 7th in which you enclosed a draft copy of the first part of the Audit Report relating to the management of the California RMP. As you have indicated, these findings pertain to an organizational entity composed of the California Medical Education and Research Foundation (CMERF) and the California Committee on Regional Medical Programs (CCRMP, Inc.)

You have requested our comments regarding these draft documents. Normally we would address our comments to the recommendations which appear at the end of each draft; however, since the relationship between CCRMP, Inc. and CMERF has played such a prominent role in the preliminary discussions, we believe that it is essential to set forth a historic description of how the CCRMP Inc. CMERF relationship evolved. This history appears to be fundamental to our ensuing comments on other recommendations which you might make. We believe that an accurate description of the past is critical to future judgments and developments.

The California RMP Program is based upon many voluntary cooperative arrangements, some of which have been set forth precisely in the written record and some of which had been maintained through verbal agreements. When the magnitude of these relationships is considered, it is to the credit of all people involved that they have functioned so smoothly and amicably. It is

we have been able to function in what has been described on several occasions as a highly satisfactory manner. It is our intent to express these agreements as clearly as possible in order that they may function as a backdrop to future decisions that we are required to make. In light of this, I have attempted to describe in some detail the early historical relationships that developed and pertain essentially to page 1 of the draft enclosed in your August 7th letter.

I call particular attention to the last sentence of your first paragraph which states "The Foundation serves as the recipient and disbursing agent of Federal RMP funds and retains the power to overrule any decision or action of CCRMP, Inc." This sentence is probably technically correct in a legal sense but is not an accurate reflection of the relationship that has actually existed between the two organizations. Certain commitments were made between CMERF and CCRMP, Inc. We believe these commitments have been honored to their fullest extent and, as a result, would modify significantly the implications of the above referred to statement. Therefore, below we have reviewed the historical commitments which are a matter of record, and we have provided our interpretation of their effect.

Public Law 89-239 was signed into law on October 6, 1965. Even before the enabling legislation was signed, however, interested parties were meeting together in California to consider the implications of the proposed program. On June 15, 1965, four months before the law was signed, a meeting of the Deans of the schools of medicine, representatives from the California Medical Association, and others met in the office of the State Director of Public Health to discuss the possible implementation of this program. Although everyone present anticipated the passage of the legislation, there was a commitment to

pursue the objectives of the program whether or not it passed. Dr. MacLaggan, representing the California Medical Association, proposed the creation of a statewide planning committee to accomplish in heart disease, cancer and stroke planning what had been done in hospital planning. The group concluded that such a coordinated approach was desirable and that the staff members from the schools and other agencies should get together to plan the next steps. Dates were set for future meetings of the Committee, which later became CCRMP, Inc.

At that point in time (1965), California enjoyed an unusual insight into the emerging program since one of the staff members of the DeBakey Commission which led to the drafting of enabling legislation to create Regional Medical Programs was Dr. Borhani, Chief of the Bureau of Chronic Diseases in the California State Department of Public Health. Dr. Borhani was instrumental in informing the Committee of the purposes of the new program and he also functioned as staff along with others from the State Department of Public Health to the new Committee. The Committee at this point became known as the California Committee to Consider Implementation of the Recommendations of the President's Commission on Heart Disease, Cancer, and Stroke. Some months later it was incorporated as "The California Coordinating Committee for Training, Research, Education and Demonstrations in the Fields of Heart Disease, Cancer, Stroke and Related Diseases." This name proved to be unmanageable. Later the Articles of Incorporation were changed to name the corporation "California Committee on Regional Medical Programs." To simplify this discussion, we will refer to the organization as CCRMP, although this designation came later in its development.

CCRMP and its staff group, which became known as the Committee of Staff Consultants, continued to meet in the latter half of 1965. During this period they began the development of a statewide planning grant and continued to enlarge the membership of the organization. The California Hospital Association was the first to be added. Later in the year, the California Heart Association and the California Division of the American Cancer Society were added, as well as the Deans of the Schools of Public Health, as participating members of the committee. This brought representation on the Committee up to a total of 18.

On September 16, 1965, the Committee had as its guests Dr. William Stewart, who then was Director of the National Heart Institute and later became Surgeon General, and Dr. Stuart Sessoms, Deputy Director of the National Institutes of Health. They outlined the provisions of the Regional Medical Program legislation which was then about to be approved by the Congress. The Committee expressed again its interest in pursuing the goals of the legislation and developing an application to be submitted to the National Institutes of Health for a planning grant to develop Regional Medical Programs (then better known as heart disease, cancer and stroke) in California.

By the time of the next meeting of the Committee, Public Law 89-239 had been signed into law. CCRMP began the consideration of tentative regional boundaries and established a subcommittee to draft the application for the planning grant to be submitted to the entire CCRMP for its consideration.

On December 18, 1965, the CCRMP met again to give further consideration to

the evolving planning grant application, added to its membership the newly developed School of Medicine at Davis, and then considered the question of incorporation into a nonprofit independent organization to carry out the RMP program in California. The California State Department of Public Health was asked to act as staff and secretariat to the proposed nonprofit corporation and to prepare all documents necessary for incorporation. It was further decided to submit the final draft of the planning grant application to Washington as soon as it was fully developed.

During the first part of 1966, the Committee continued its refinement of the planning application and the development of the papers necessary for incorporation. On June 8, 1966, the Secretary of State acknowledged CCRMP as a nonprofit corporation. Earlier, on May 12, 1966, the planning grant application was submitted to the Division of Regional Medical Programs for funding. A site visit to review the planning proposal by a committee of the National Advisory Council of DRMP was held on July 14, 1966, in Berkeley. The site visit team considered many pertinent matters, but the end result was that California was designated as a single region and that CCRMP was to be considered as the applicant agency for planning grants. The original planning grant application had to be modified as a result of the site visit to indicate that California was defined "as a single region for planning" and that CCRMP, which had 18 members at this point, had to be expanded by 8 advisory members "broadly representative of the public, including labor, management, consumer, minority group, and other community interests." The advisory group members did not become a part of the corporation but when added to the Board of Directors of the corporation the combined groups of people became the Regional Advisory Group to the program. It was decided that those

agencies and institutions wishing to participate in the Regional Medical Programs in California would do so by presenting proposals to CCRMP, which would render decisions on them in terms of their applicability to the planning being done by CCRMP and its objectives. CCRMP would then send the applications, along with CCRMP comments, for consideration by the National Advisory Council and if approved, for funding.

On June 30, 1966, the Board of Directors of the California Medical Education and Research Foundation met; as a part of their agenda, the matter of the emerging Regional Medical Programs and CCRMP was discussed. The CMA representatives on CCRMP discussed the importance of the activities of CCRMP and indicated that CMERF should be an active participant in the program.

On August 18, 1966, Dr. Nemat Borhani, who had been designated as Coordinator for the emerging Regional Medical Program in California, was informed by telephone that the National Advisory Council of DRMP had recommended award of the amount requested by CCRMP for planning. California had submitted a statewide planning application of \$223,400 and an additional request for \$2.5 million for contracting with the various medical schools for planning at the Area level. The statewide application was recommended, but the \$2.5 million request for contracting was withheld pending further study. It was during this discussion that the problem of fiscal responsibility was first noted. The record of the telephone conversation existing at RMP offices at the federal level, states that "We then discussed the problem of (CCRMP) as a new nonprofit institution. Dr. Borhani said that he had anticipated the need for financial assurances and he would discuss this problem with Dr. Breslow, Director of the California State Department of Health, and officials of the University of

General Accounting Office and requested specific details from our Grants Management Branch."

In a letter dated August 19, 1966, Dr. Borhani received official notification that the amount of \$223,000 for planning by CCRMP had been recommended to the Surgeon General for approval. The letter stated that the remaining \$2.5 million requested would be subject to evidence that the supplemental grant request made by institutions within the California Region did not represent independent actions on their part but instead actually coordinated efforts emerging through the California program for RMP. The letter pointed out the problem of financial accountability of a new nonprofit corporation and made suggestions for formal financial backing of the corporation from other sources.

CCRMP then referred the matter of financial accountability to its Staff Consultant group. According to the October 3, 1966, minutes of the Staff Consultants group, the matter was brushed off lightly with the assurance that it could be handled by securing a bond from an insurance company. The Committee advised Dr. Borhani to confer with the Chairman of CCRMP and to proceed with the arranging of an appropriate bond. There was reason to believe that this could be accomplished since, by that time, one nonprofit corporation had been established to manage an RMP region. Wisconsin RMP, Inc. had been established and awarded a grant for planning in September of 1966. Ten Regional Medical Programs had been funded prior to that but, in each case, the grantee had been an established university or medical school. Wisconsin RMP, Inc. had no funds of its own and its Board of Directors consisted of three persons---the two presidents of the universities in Wisconsin, plus a retired insurance executive.

This Board of three was ultimately expanded to a much larger Board but as a Board of three had no problem in securing a bond that would meet the requirements of the granting agency. An insurance group was contacted in order to secure a bond for CCRMP and arrangements were made for the members of CCRMP to sign the bond at its regular meeting on October 12, 1966. By this time the planning grant award had been processed, the Surgeon General had been advised of the award, and it was to be made in the group of awards slated for November 1, 1966.

According to the minutes of CCRMP for October 12, 1966, CCRMP was advised that it would function as an independent agency and become the sole recipient of funds under the provisions of the planning grant application submitted from California. Dr. Robert Glaser, Dean of Stanford Medical School and Chairman of CCRMP, advised the Committee of its responsibilities in processing, reviewing, and funding proposals throughout the state. October 12, 1966, proved to be one of the more crucial meetings of CCRMP because then the question of financial responsibility for the funds was raised. A telegram from Dr. Robert Marston, Associate Director of NIH and Director of DRMP, stated that "Supplements to a planning grant must be made to a grantee who assumes the same responsibilities involved in the initial grant." This indicated that the sums for which CCRMP would be responsible could grow into a substantial amount. When the discussion of the insurance bond came up, the members of CCRMP proceeded to sign the pre-arranged bond. Representatives of the insurance company appeared and proceeded with the necessary signatures. According to the minutes of the meeting of that date, during the discussion with the insurance company representatives, it became apparent that the bond was not "to be an insurance bond, but a liability, requiring commitment from Committee members

to repay the insurance company up to the total amount underwritten (\$100,000) in case of mismanagement." After that discussion, it was decided that the members of the Committee could not sign such a document on their own or on behalf of their institutions, which fact seemed, at that point in time, to make them or their institutions liable for the amount of the grant. It was then decided that the lawyers of the California Medical Association, the California Hospital Association, and the University of California should discuss the matter further and contact Dr. Marston's office to find a solution to the question of fiscal responsibility.

There is an asterisk in those minutes of October 12, 1966, which refer to an explanation later added to the minutes. This explanation states:

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P. Ward → "After the meeting of October 12, this subject was discussed by the attorneys and the ultimate solution found was to ask the California Medical Education and Research Foundation of the California Medical Association to serve as Fiscal Agent for the California Committee. This was brought to the attention of the members of the California Committee (CCRMF), who gave their approval. Subsequently, the Division of Regional Medical Programs was contacted, which also approved of the solution. The face sheet of the grant application was thus revised and mailed to Washington for review and consideration. Under this new arrangement, the California Medical Education and Research Foundation (CMA) will act as the fiscal agent and the California Committee as the operating body for implementation of the objectives of the planning grant application. Thus, Mr. Howard Hassard of the California Medical Association signed the new face sheet in lieu of Mr. Mark Berke, Secretary-Treasurer of the California Committee. Other items on the face sheet remained the same."

The following day Dr. Borhani called the Division of Regional Medical Programs to inform them of the action taken by CCRMF concerning the bond. This call, of course, placed the award which was to be made at any moment in question. According to a memo to the files dated October 14, 1966, by Mr. Karl Yordy, then Assistant Director, The Division of Regional Medical Programs, discussed

the question of the bonding with Grants Management. Their conclusion was that the insurance company would try to recover its losses from the organization or individual who was covered by the bond; however, it was their opinion that in this case the insurance company would have to move against the corporation rather than individual members of the Board of Directors.

Unfortunately at this point in time, the government was only beginning its relationship with what it later termed "Financially Dependent Organizations". These are organizations that have relatively no money of their own and are almost entirely dependent upon Federal funds for their support. In fact, the manual for financially dependent organizations was not developed by the Controller of HEW until June of 1970. CCRMP was one of the earliest RMP organizations of this type and few knew how to proceed with the appropriate financial assurances. Since that time CCRMP itself has developed several of these organizations, including the Drew School which is now a multimillion dollar operation. Undoubtedly we will develop more. But at that point in 1966 the rules of the game were indefinite.

On October 24, 1966, Mr. Robert Lindee, Assistant Dean at Stanford Medical School and acting for the Chairman of CCRMP, Dean Robert Glaser, went to the Division of Regional Medical Programs to discuss this matter. According to a memo for the record by Karl Yordy with whom this discussion took place, the conversation covered the following matters:

"Mr. Robert Lindee, Assistant Dean at Stanford Medical School, came to my office to discuss the problems which had been encountered by the California Coordinating Committee in obtaining the performance bond. As reported to me by Dr. Borhani, the insurance agent in San Francisco,

who had obtained the bond, did indicate to the group that each of the officers of the corporation who signed the bond could be held financially responsible as individuals if the insurance company was required to pay the Federal government because of an audit disallowance. This requirement was unacceptable to the members of the corporation; and as a result, their signatures were withdrawn from the bond because this requirement for the bond seemed to be different than the bond obtained by the Wisconsin Regional Medical Program, Inc., even though the insurance company involved was the same (The Northwestern National Insurance Company of Milwaukee). I called Dr. John Hirschboeck, Program Coordinator for the Wisconsin Regional Medical Program, Inc., to discuss his understanding of the requirements of their bond. Dr. Hirschboeck explained that they had originally contacted a bonding company in Baltimore which would have made the same requirement of personal financial responsibility. Finding this unacceptable, they contacted the Northwestern National Insurance Company and were able to procure the bond without this requirement because of the personal character and standing in the community of the officers of the corporation.

Dr. Hirschboeck then called me back after talking to their insurance agent and said that it was the Wisconsin Regional Medical Program, Inc. that was bonded and not the individual members of the corporation. The insurance agent also suggested that he saw no reason why the Northwestern National Insurance Company would not allow the same procedure with the California corporation if the character and standing of the incorporators in California was demonstrated. The agent also indicated that perhaps the insurance agent in San Francisco with whom the California group was dealing was being overly cautious."

When the attorneys for the California Medical Association, California Hospital Association, and the Universities discussed the possible way out of the dilemma of fiscal responsibility, the California Hospital Association and CMERF both were suggested as possible fiscal agents.

The term "fiscal agent" was used constantly throughout the discussions and in the various communications. The term "grantee" did not appear until such time as it became obvious that the proposal which had been submitted and approved would need a new "face sheet". There is perhaps a subtle distinction between a "fiscal agent" and a "grantee". And there was a lack of knowledge on the part of the Committee concerning the technical provisions of Section 903 of

the Regional Medical Program Law. It can be seen, though, from the written agreement between CCRMP and CMERF that the two organizations had a somewhat different concept of "grantee" than finally emerged within Regional Medical Programs Service.

In a letter dated October 27, 1966, to Dr. Marston as Chief of DRMP, Dr. Robert Glaser, Chairman of CCRMP, set forth the agreement that had been reached by the CCRMP and CMERF:

"Attached herewith is a revised FACE SHEET for the planning grant application from the State of California. The initial application showed the applicant organization as the California Committee on Regional Medical Programs, and we are now requesting that the California Medical Education and Research Foundation be substituted as the official applicant for and recipient of a planning grant under PL 89-239. Change in applicant is requested in order to meet administrative and financial requirements of an applicant receiving a grant under PL 89-239.

The change in applicant in no way changes the planning procedures as outlined in our initial application. Written assurance has been received by the California Committee that California Medical Education and Research Foundation will act solely in an administrative capacity and that policies heretofore or hereafter adopted by the California Committee will be governing, and subject only to California Medical Education and Research Foundation's primary commitment to administer and account for the funds in accordance with the law and applicable regulations and instructions of the Surgeon General.

The following statement of the policy has been agreed upon by the California Committee and California Medical Education and Research Foundation. The California Medical Education and Research Foundation, a non-profit, tax exempt education and research organization established in 1962 by the California Medical Association, and acting on behalf of the California Committee on Regional Medical Programs, will serve as the recipient and disbursing agent of planning grant funds received from the U.S. Public Health Service for the purpose of complying with the regulations under Public Law 89-239.

In assuming this responsibility, California Medical Education and Research Foundation will:

1. Comply with the specific provisions of Section 903 of the Public Health Service Act; and with

2. All administrative regulations to assure the successful performance

California Medical Education and Research Foundation has, for several years, demonstrated its fiscal responsibility by virtue of its past history of performance in receiving grants from Federal, state, and local agencies, and in accounting for the use of such monies following the completion of studies it has either undertaken or for which it has been responsible for supervising.

In assuming a similar responsibility, in serving in a fiscal and accounting capacity on behalf of the California Committee on Regional Medical Programs, the California Medical Education and Research Foundation will be guided by, and adhere to, the policy decisions of the California Committee on Regional Medical Programs (as adopted by the full Committee or the Executive Committee of that organization which may act on its behalf). In so doing, however, the California Medical Education and Research Foundation will exert only those veto powers which are in conformity with or required to adhere to Title IX of the Public Health Service Act, but will in no manner make unilateral decisions which are at variance with the goals and objectives of the California Committee on Regional Medical Programs as contained in its planning grant application, or with the conditions of performance established by the California Committee on Regional Medical Programs and its Advisory Committee."

On October 28, 1966, the Board of Directors of CMERF met. One of the matters on its agenda was CMERF's fiscal role on behalf of CCRMP. The Board of Directors took under consideration a copy of the letter quoted above which Dr. Glaser had written to Dr. Marston. The minutes of that meeting read as follows:

"Doctor MacLaggan provided the background regarding the Committee's formation and its efforts to secure a planning grant from the National Institutes of Health. He reported that one of the obstacles to the actual receipt of the monies was the absence of an agency which would be responsible for the fiscal and accountability responsibilities which P.L. 89-239 and the National Advisory Council required. The capabilities of CMERF had therefore been offered and accepted by the California Committee. Mr. Hassard explained the conditions under which CMERF could assume this fiscal role. The conditions cited were unanimously approved by the Board. Mr. Hassard then read the letter addressed by Dean Robert J. Glaser to Doctor Robert Q. Marston in which these conditions were offered as a basis for designating CMERF as the responsible fiscal agency to serve on behalf of the California Committee. The Board unanimously approved of the conditions set forth in Doctor Glaser's letter of October 27 which would revise the planning grant application originally submitted by the California Committee on Regional Medical Programs, and then authorized Mr. Hassard to sign the revised application Face Sheet."

The following day a new face sheet was prepared and signed by Mr. Hassard. The face sheet was added to the project proposal as it was originally prepared and approved by the National Advisory Council when CCRMP was to be the grantee.

There were no changes or amendments made except for the face sheet.

On November 10, 1966, Mr. Hassard then received notification of approval of the planning grant application as submitted by the California Medical Education and Research Foundation in the amount of \$223,400. On the same day, however, a letter was addressed to Dr. Nemat Borhani from the Chief, Development and Assistance Branch, Division of Regional Medical Programs, indicating that DRMP had "concern that the applicant organization, the California Medical Education and Research Foundation, cannot be considered to have the experience in handling large and numerous Federal grants and subcontracts nor the financial resources which would be essential if it were to serve as the grantee organization for multiple large supplementary or operational grants". The letter then went on to suggest that California should arrange to adopt a plan comparable to that being contemplated for Texas at that time where one of the universities would serve as the grantee. This letter again threw the RMP Program in California into consternation but it did raise the point that Texas was developing agreements among institutions where the grantee was protected in the event that any one of the participating institutions misspent or mismanaged any of the funds. These agreements, in essence, made the institutions mispending the funds nominally responsible for the exception in place of the grantee. No one knew the validity of these agreements, but most assumed that they could be made to work.

The above letter of November 10 was followed almost immediately by another letter from Dr. Marston indicating in effect that CCRMP should ignore the previous letter. Dr. Marston stated that "Though we suggested the possibility of those in California adopting an arrangement similar to that in Texas, you should not feel bound

by this suggestion in any way."

Dr. Marston indicated that if the California Medical Education and Research Foundation gave evidence of the existence of legally binding agreements with other institutions or agencies within the region assuring that the participating institutions would expend funds only in accordance with an approved budget and would be required to reimburse CMERF for any funds which might be subsequently disallowed, then the arrangement would be satisfactory. This position was ultimately accepted by CCRMP and the award that had already been made was accepted.

The check for the first portion of the funding had arrived and had been deposited in a newly created account under CMERF's name (known as CMERF II) but devoted solely to the operation of CCRMP, Inc. On February 24, 1967, the Board of Directors of CMERF met to confirm certain interim actions taken in regard to CCRMP by CMERF. The minutes indicate that the Board took the following actions:

"CONFIRMATION OF APPOINTMENT OF PAUL WARD AS EXECUTIVE DIRECTOR OF CCRMP

The Board confirmed, by unanimous vote, the appointment of Paul Ward as Executive Director of the California Committee on Regional Medical Programs; such appointment effective as of January 1, 1967, the date on which Mr. Ward was employed by the California Medical Education and Research Foundation.

RELATIONSHIP OF CMERF TO CCRMP

The Board reviewed the circumstances surrounding the CMERF application for planning grant funds for regional medical programs under P.L. 89-239. It reiterated the facts that: CMERF is the legal grantee of such funds; that the 28-member advisory committee which is designated as the California Committee on Regional Medical Programs (CCRMP) is, in fact, the advisory committee to CMERF for the planning grant application which has previously been received, as well as for grant requests still pending; that the Executive Committee on the CCRMP could logically serve as the operating committee of the CCRMP, and that at least one officer

FINANCIAL STRUCTURE AND ACCOUNTABILITY OF REGIONAL MEDICAL PROGRAM FUNDS

Mr. Hassard informed the Board of the bookkeeping system which had been developed. The system is so designed as to maintain separate bank accounts and records for the receipts and expenditures of each of the organizations and institutions involved in carrying out planning programs. Thus, CMERF itself has been designed as CMERF 1. The initial grant received on behalf of the statewide planning staff, of which Paul Ward is Executive Director, is CMERF 2. The funds to be received in the future will similarly be designated numerically for each of the medical schools, CHA, and CMA. The Board approved of the system which has been developed."

Thus, the CMERF Board has honored its part of the above agreement. It established a bank account (CMERF-2), devoted solely to CCRMP purposes which has been administered according to "the policy decisions of the CCRMP." CMERF has exercised no veto powers and has made no "unilateral decisions which are at variance with the goals and objectives of CCRMP". Although CMA and its local societies have at times taken positions which might be interpreted as limiting the scope of RMP, these positions have not been enforced through the CMERF fiscal mechanism but instead have been presented for debate and decision by the full CCRMP Regional Advisory Group. The executive Committee of CCRMP has served as the operating committee making most fiscal decisions not deemed proper to refer to the full CCRMP. On the other side of the agreement CMERF has "in serving in a fiscal and accounting capacity on behalf of CCRMP" caused periodic audits to be made and accounting practices to be reviewed by their retained audit firm, John F. Forbes and Co. This firm has acted both as auditors of accounts and advisors on accounting practices. In summation, generally the terms of the original agreement which was approved by DRMP have been complied with and to date there has been no need or request to modify the arrangement. We would suggest that the phrase "retains the power to overrule" goes beyond the facts of the situation in view of the history and the written agreement.

Turning now to the recommendations which appeared in Draft Finding No. 1, you have recommended that we expand the current requirement for Area Office budgeting by functional categories on the RMP Form 8, to include budget data for (a) developing project proposal and (b) monitoring the execution of approved projects. Your second recommendation is that we require Area Offices to account for and report actual costs by the functional categories established in the core budgets and explain any significant deviations from the budget.

From the point of view of sound and effective management, no one could argue with the value of these recommendations. As program managers, we are also in general agreement with the substance of the draft critique leading up to these recommendations and in fact have taken steps to respond to the "PROGRAM FOR IMPROVING THE QUALITY OF GRANTEE MANAGEMENT" published by the Controllers of DHEW on June 1970. We do believe, however, that it is necessary to consider both the history of the development of the California RMP program and the fact that the program has been engaged in a far wider spectrum of activities at the Area level than is indicated in the body of the Draft. Many of these activities lend themselves to a structured planning and budgeting system while others have defied the best thinking of institutional and Federal management experts. Because of the philosophy advanced in the early stages of the program and the program's history of development, we, as managers, have been constantly made aware that our management policies and procedures should not stifle initiative and innovation or produce an institution that is so rigid that it would be unable to respond to the unusual dictates and objectives of the program.

The early Guidelines were filled with idealistic implorations to maintain a

of the program made unusual efforts to indicate that program direction would not come from the top but instead ideas should emerge from the lowest grass-root level possible and filtrate upward for funding and support. The fact that only very general guidelines were published about the program and virtually no regulations were issued indicates the extreme attempts that were made by DHEW to see that the program operated from the bottom up and not from the top down.

The Guidelines were filled with such vague statements as this effort "calls for the development of Regional Medical Programs which create an effective environment for continuing adaptation, innovation, and modification", and "The Regional Medical Programs present the medical interest within a region with an instrument of synthesis that can capitalize on and reinforce the various trends and resources," and "It is the interaction of these trends at this time, rather than an abstract conceptualization, which not only justifies but requires a synthesizing force such as the Regional Medical Programs" and "Among various identified needs, there also are often relationships which, when perceived, offer even greater opportunities for solutions." "The danger of project visualization, which is akin to tunnel vision, must be guarded against." The above sentences in the Guidelines indicate the vagueness with which the program was begun. Yet this was deliberate in order to assure that the program would avoid direction from above and attempt to capitalize to the greatest degree possible on actions and concepts that would emanate from the lowest possible level within the health care system. This may have been highly idealistic and impractical, but it was a deliberate attempt to determine whether or not progress could be made in this fashion and thereby avoid directives and regimentation from the top down.

At this point in time that philosophy may seem rather far afield from the question of budgeting and accounting procedures. It did permeate all aspects of the program however, and as people in institutions become involved in the program, essentially from a voluntary point of view, they jealously guarded that concept in all of the various areas of operation, including fiscal management.

The development of the California region involved other facts and conditions that tended to emphasize this philosophy. As indicated earlier in this letter, several university medical centers were involved in forming what eventually became CCRMP, Inc. Some of these medical centers had developed planning grant applications in 1965 and submitted them to NIH for funding during the time when the combined group was developing theirs. As a result of the 1965 site visit, they were obligated to withdraw these planning grant applications and join with CCRMP, Inc. in the planning process. As the record indicates, the first site visit decided that California would be one region for planning. Although a later site visit team and the National Advisory Council decided that California would also be a region for operations, at the time of the first planning grant some of the university medical centers believed that they would have their own region when they entered the operational stage. The fact that California was made a region for operational purposes was accepted with some reluctance by the centers concerned. There was a continuous struggle for local autonomy in all aspects of the program and subsequent site visit teams gave de facto recognition to the local autonomy. Although there was never any question raised by the site visit teams or by the National Advisory Council concerning California's status as a region, recognition for local autonomy was given in the way the site visits were structured. When site visit teams came to California at later dates, not only did they review the region as a whole, but

they also scheduled individual and separate visits with the areas concerned.

As management we anticipated the need for better budgetary and expenditure controls, although we felt that we had little authority upon which to proceed. Prior to the publication by DHEW in June 1970 of its manual for "Financially Dependent Organizations," our Region Office spent a considerable period of time exploring the possible implementation of program budgeting. It was discussed with the areas and it was discussed with the fiscal people at the university level. The concept was eventually abandoned, however, with the advent of the new RMPS forms for reporting and the deliberations of the FAST TASK Report. We believed that we were meeting the requirements of the program by converting to the new forms, and we further believed that a further tightening of the system was not feasible at that time.

We would make two general comments about the implications of the Draft Report. The first is that it lists five basic functions of each Area Office. We believe that this is a rather narrowly drawn definition of Area Office functions and might lead to the conclusion that the development and management of funded projects is an adequate measure of the Area Office's success or failure. We believe that this conclusion would be erroneous and extremely unfortunate if left to stand as valid. Project development and management is but one product of the activities intended to be the function of RMP. Other activities, such as establishing regional cooperative relationships, the acts of providing information and resources to providers that could not otherwise be obtained by them, and the acts of keeping discussions going about the health needs and providing suggestions as to how they might be resolved certainly are as important as project development itself. These latter acts, while possible

of describing and listing, often defy cost analysis simply because no one can estimate the value of their final result. In addition, any listing of the functions of an Area Office would have to be considered a perpetually changing list. To illustrate but one example, functions 1 and 2 listed in the Draft indicate that the Areas are identifying the health care needs and assessing medical resources in the Area. To be sure, we have been doing this to the extent that we have found it necessary, but essentially this should be the function of Comprehensive Health Planning. To the degree that CHP is able to perform its functions in these two areas, RMP can then abandon its efforts. Certainly we should be phasing out of these two activities as CHP becomes more sophisticated and able to accomplish its own objectives. We would then respond to the needs and resources as indicated in the CHP determinations.

The second implication is that projects are developed which are of measurable magnitude and that, in essence, the program staff in the Area is the sole source and developer of the proposal. It is difficult for us to determine how the cost figure cited in the Draft was determined, but it creates a completely erroneous concept of what is being done. Some projects are developed in their totality by the Area Staff, but in keeping with the original philosophy of the program, many projects are developed by groups outside of the Area Office and are submitted to them for some degree of assistance in their final preparation. These projects are then reviewed at the Area level by the Area Advisory Group to determine their appropriateness to meet Area needs as well as the appropriateness of the manner in which the project proposes to meet the needs. This manner of program development follows from RMP's NIH heritage. It will be recalled that independent groups, usually in universities and

medical centers, develop proposals and submit them to NIH for funding.

One of the major additions of the RMP program was that there was to be in existence a paid staff to help the community develop proposals to submit for funding. It would be erroneous if we assume that all NIH proposals are prepared by unpaid interested parties, since many NIH proposals are prepared by persons borrowed from other NIH funded projects. But the RMO ^P approach was to be a more honest and direct approach. We were to provide paid staff to help the community develop a proposal to do what it believed needed to be done.

Another aspect that has to be emphasized is that the Area Staff prepares projects not only for RMP funding but also for a wide variety of other funding sources. Although on first glance this might seem to be a distortion of RMP purposes, it nevertheless has been incorporated into the normal routine of the program. Projects funded from other sources reach into several millions of dollars, including emergency medical services projects that were funded from other sources, Area Health Education Center projects which are about to be funded by the Bureau of Health Manpower, and several other types of projects aimed at NIH funding. In addition, there is always an element of gambling present in attempting to meet the health needs of the community. In each fiscal year there are always earmarked funds. Those who are able to correctly anticipate these earmarkings can begin the development of proposals early enough to assure funding. If you begin proposals early, however, and the earmarkings failed to materialize, then sometimes you have gambled in vain. Last year funds were earmarked for Emergency Medical Services, Area Health Education Centers, Kidney Disease, among others. Persons or regions that anticipated these earmarkings usually had an advantage.

for adoption.

In short, we wish to state that we are more than willing to recommend to CCRMP that we should move in the direction indicated by the recommendations, and state further that some progress has already been made toward this end. Our problem with the draft statement is the narrow definition of area office function and the assumption that functional budgeting and cost accounting would greatly change the production pattern of the program.

Progress which has been made includes the formation of a Program Review Committee of the Regional Advisory Group which reviews program and fiscal reports three times per year. A fiscal management information system provides data based on expenditure reports from the area offices on a monthly basis. Our Regional Evaluators Committee is currently considering methods of structuring and streamlining fiscal and program reporting and is developing an improved instrument to replace our current reporting form.

We continue to believe that the development of effective planning, budgeting and reporting systems must involve our area offices and must take into account their needs and resources. As a result, we have undertaken the development of a rational system that assumes the necessity of placing useful information in the hands of responsible managers at all levels.

Very truly yours,

Paul D. Ward



CALIFORNIA COMMITTEE ON REGIONAL MEDICAL PROGRAMS

25 August 1972

James C. MacLaggan, M. D.
Chairman

C. John Tupper, M. D.
Vice Chairman

David E. Olsson
Secretary-Treasurer

Paul D. Ward
Executive Director

Mr. James H. Kerr
Branch Manager
DHEW Audit Agency
San Francisco Branch
681 Market Street, Room 609
San Francisco, California 94105

Dear Mr. Kerr:

This will acknowledge your letter of August 7th in which you enclosed a draft copy of the first part of the Audit Report relating to the management of the California RMP. As you have indicated, these findings pertain to an organizational entity composed of the California Medical Education and Research Foundation (CMERF) and the California Committee on Regional Medical Programs (CCRMP, Inc.)

You have requested our comments regarding these draft documents. Normally we would address our comments to the recommendations which appear at the end of each draft; however, since the relationship between CCRMP, Inc. and CMERF has played such a prominent role in the preliminary discussions, we believe that it is essential to set forth a historic description of how the CCRMP Inc. CMERF relationship evolved. This history appears to be fundamental to our ensuing comments on other recommendations which you might make. We believe that an accurate description of the past is critical to future judgments and developments.

The California RMP Program is based upon many voluntary cooperative arrangements, some of which have been set forth precisely in the written record and some of which had been maintained through verbal agreements. When the magnitude of these relationships is considered, it is to the credit of all people involved that they have functioned so smoothly and amicably. It is

we have been able to function in what has been described on several occasions as a highly satisfactory manner. It is our intent to express these agreements as clearly as possible in order that they may function as a backdrop to future decisions that we are required to make. In light of this, I have attempted to describe in some detail the early historical relationships that developed and pertain essentially to page 1 of the draft enclosed in your August 7th letter.

I call particular attention to the last sentence of your first paragraph which states "The Foundation serves as the recipient and disbursing agent of Federal RMP funds and retains the power to overrule any decision or action of CCRMP, Inc." This sentence is probably technically correct in a legal sense but is not an accurate reflection of the relationship that has actually existed between the two organizations. Certain commitments were made between CMERF and CCRMP, Inc. We believe these commitments have been honored to their fullest extent and, as a result, would modify significantly the implications of the above referred to statement. Therefore, below we have reviewed the historical commitments which are a matter of record, and we have provided our interpretation of their effect.

Public Law 89-239 was signed into law on October 6, 1965. Even before the enabling legislation was signed, however, interested parties were meeting together in California to consider the implications of the proposed program. On June 15, 1965, four months before the law was signed, a meeting of the Deans of the schools of medicine, representatives from the California Medical Association, and others met in the office of the State Director of Public Health to discuss the possible implementation of this program. Although everyone present anticipated the passage of the legislation, there was a commitment to

pursue the objectives of the program whether or not it passed. Dr. MacLaggan, representing the California Medical Association, proposed the creation of a statewide planning committee to accomplish in heart disease, cancer and stroke planning what had been done in hospital planning. The group concluded that such a coordinated approach was desirable and that the staff members from the schools and other agencies should get together to plan the next steps. Dates were set for future meetings of the Committee, which later became CCRMP, Inc.

At that point in time (1965), California enjoyed an unusual insight into the emerging program since one of the staff members of the DeBakey Commission which led to the drafting of enabling legislation to create Regional Medical Programs was Dr. Borhani, Chief of the Bureau of Chronic Diseases in the California State Department of Public Health. Dr. Borhani was instrumental in informing the Committee of the purposes of the new program and he also functioned as staff along with others from the State Department of Public Health to the new Committee. The Committee at this point became known as the California Committee to Consider Implementation of the Recommendations of the President's Commission on Heart Disease, Cancer, and Stroke. Some months later it was incorporated as "The California Coordinating Committee for Training, Research, Education and Demonstrations in the Fields of Heart Disease, Cancer, Stroke and Related Diseases." This name proved to be unmanageable. Later the Articles of Incorporation were changed to name the corporation "California Committee on Regional Medical Programs." To simplify this discussion, we will refer to the organization as CCRMP, although this designation came later in its development.

CCRMP and its staff group, which became known as the Committee of Staff Consultants, continued to meet in the latter half of 1965. During this period they began the development of a statewide planning grant and continued to enlarge the membership of the organization. The California Hospital Association was the first to be added. Later in the year, the California Heart Association and the California Division of the American Cancer Society were added, as well as the Deans of the Schools of Public Health, as participating members of the committee. This brought representation on the Committee up to a total of 18.

On September 16, 1965, the Committee had as its guests Dr. William Stewart, who then was Director of the National Heart Institute and later became Surgeon General, and Dr. Stuart Sessoms, Deputy Director of the National Institutes of Health. They outlined the provisions of the Regional Medical Program legislation which was then about to be approved by the Congress. The Committee expressed again its interest in pursuing the goals of the legislation and developing an application to be submitted to the National Institutes of Health for a planning grant to develop Regional Medical Programs (then better known as heart disease, cancer and stroke) in California.

By the time of the next meeting of the Committee, Public Law 89-239 had been signed into law. CCRMP began the consideration of tentative regional boundaries and established a subcommittee to draft the application for the planning grant to be submitted to the entire CCRMP for its consideration.

the evolving planning grant application, added to its membership the newly developed School of Medicine at Davis, and then considered the question of incorporation into a nonprofit independent organization to carry out the RMP program in California. The California State Department of Public Health was asked to act as staff and secretariat to the proposed nonprofit corporation and to prepare all documents necessary for incorporation. It was further decided to submit the final draft of the planning grant application to Washington as soon as it was fully developed.

During the first part of 1966, the Committee continued its refinement of the planning application and the development of the papers necessary for incorporation. On June 8, 1966, the Secretary of State acknowledged CCRMP as a nonprofit corporation. Earlier, on May 12, 1966, the planning grant application was submitted to the Division of Regional Medical Programs for funding. A site visit to review the planning proposal by a committee of the National Advisory Council of DRMP was held on July 14, 1966, in Berkeley. The site visit team considered many pertinent matters, but the end result was that California was designated as a single region and that CCRMP was to be considered as the applicant agency for planning grants. The original planning grant application had to be modified as a result of the site visit to indicate that California was defined "as a single region for planning" and that CCRMP, which had 18 members at this point, had to be expanded by 8 advisory members "broadly representative of the public, including labor, management, consumer, minority group, and other community interests." The advisory group members did not become a part of the corporation but when added to the Board of Directors of the corporation the combined groups of people became the Regional Advisory Group to the program. It was decided that those

agencies and institutions wishing to participate in the Regional Medical Programs in California would do so by presenting proposals to CCRMP, which would render decisions on them in terms of their applicability to the planning being done by CCRMP and its objectives. CCRMP would then send the applications, along with CCRMP comments, for consideration by the National Advisory Council and if approved, for funding.

On June 30, 1966, the Board of Directors of the California Medical Education and Research Foundation met; as a part of their agenda, the matter of the emerging Regional Medical Programs and CCRMP was discussed. The CMA representatives on CCRMP discussed the importance of the activities of CCRMP and indicated that CMERF should be an active participant in the program.

On August 18, 1966, Dr. Nemat Borhani, who had been designated as Coordinator for the emerging Regional Medical Program in California, was informed by telephone that the National Advisory Council of DRMP had recommended award of the amount requested by CCRMP for planning. California had submitted a statewide planning application of \$223,400 and an additional request for \$2.5 million for contracting with the various medical schools for planning at the Area level. The statewide application was recommended, but the \$2.5 million request for contracting was withheld pending further study. It was during this discussion that the problem of fiscal responsibility was first noted. The record of the telephone conversation existing at RMP offices at the federal level, states that "We then discussed the problem of (CCRMP) as a new nonprofit institution. Dr. Borhani said that he had anticipated the need for financial assurances and he would discuss this problem with Dr. Breslow, Director of the California State Department of Health, and officials of the University of

General Accounting Office and requested specific details from our Grants Management Branch."

In a letter dated August 19, 1966, Dr. Borhani received official notification that the amount of \$223,000 for planning by CCRMP had been recommended to the Surgeon General for approval. The letter stated that the remaining \$2.5 million requested would be subject to evidence that the supplemental grant request made by institutions within the California Region did not represent independent actions on their part but instead actually coordinated efforts emerging through the California program for RMP. The letter pointed out the problem of financial accountability of a new nonprofit corporation and made suggestions for formal financial backing of the corporation from other sources.

CCRMP then referred the matter of financial accountability to its Staff Consultant group. According to the October 3, 1966, minutes of the Staff Consultants group, the matter was brushed off lightly with the assurance that it could be handled by securing a bond from an insurance company. The Committee advised Dr. Borhani to confer with the Chairman of CCRMP and to proceed with the arranging of an appropriate bond. There was reason to believe that this could be accomplished since, by that time, one nonprofit corporation had been established to manage an RMP region. Wisconsin RMP, Inc. had been established and awarded a grant for planning in September of 1966. Ten Regional Medical Programs had been funded prior to that but, in each case, the grantee had been an established university or medical school. Wisconsin RMP, Inc. had no funds of its own and its Board of Directors consisted of three persons---the two presidents of the universities in Wisconsin, plus a retired insurance executive.

This Board of three was ultimately expanded to a much larger Board but as a Board of three had no problem in securing a bond that would meet the requirements of the granting agency. An insurance group was contacted in order to secure a bond for CCRMP and arrangements were made for the members of CCRMP to sign the bond at its regular meeting on October 12, 1966. By this time the planning grant award had been processed, the Surgeon General had been advised of the award, and it was to be made in the group of awards slated for November 1, 1966.

According to the minutes of CCRMP for October 12, 1966, CCRMP was advised that it would function as an independent agency and become the sole recipient of funds under the provisions of the planning grant application submitted from California. Dr. Robert Glaser, Dean of Stanford Medical School and Chairman of CCRMP, advised the Committee of its responsibilities in processing, reviewing, and funding proposals throughout the state. October 12, 1966, proved to be one of the more crucial meetings of CCRMP because then the question of financial responsibility for the funds was raised. A telegram from Dr. Robert Marston, Associate Director of NIH and Director of DRMP, stated that "Supplements to a planning grant must be made to a grantee who assumes the same responsibilities involved in the initial grant." This indicated that the sums for which CCRMP would be responsible could grow into a substantial amount. When the discussion of the insurance bond came up, the members of CCRMP proceeded to sign the pre-arranged bond. Representatives of the insurance company appeared and proceeded with the necessary signatures. According to the minutes of the meeting of that date, during the discussion with the insurance company representatives, it became apparent that the bond was not "to be an insurance bond, but a liability, requiring commitment from Committee members

to repay the insurance company up to the total amount underwritten (\$100,000) in case of mismanagement." After that discussion, it was decided that the members of the Committee could not sign such a document on their own or on behalf of their institutions, which fact seemed, at that point in time, to make them or their institutions liable for the amount of the grant. It was then decided that the lawyers of the California Medical Association, the California Hospital Association, and the University of California should discuss the matter further and contact Dr. Marston's office to find a solution to the question of fiscal responsibility.

There is an asterisk in those minutes of October 12, 1966, which refer to an explanation later added to the minutes. This explanation states:

ckd
P. Ward — "After the meeting of October 12, this subject was discussed by the attorneys and the ultimate solution found was to ask the California Medical Education and Research Foundation of the California Medical Association to serve as Fiscal Agent for the California Committee. This was brought to the attention of the members of the California Committee (CCRNP), who gave their approval. Subsequently, the Division of Regional Medical Programs was contacted, which also approved of the solution. The face sheet of the grant application was thus revised and mailed to Washington for review and consideration. Under this new arrangement, the California Medical Education and Research Foundation (CMA) will act as the fiscal agent and the California Committee as the operating body for implementation of the objectives of the planning grant application. Thus, Mr. Howard Hassard of the California Medical Association signed the new face sheet in lieu of Mr. Mark Berke, Secretary-Treasurer of the California Committee. Other items on the face sheet remained the same."

The following day Dr. Borhani called the Division of Regional Medical Programs to inform them of the action taken by CCRNP concerning the bond. This call, of course, placed the award which was to be made at any moment in question. According to a memo to the files dated October 14, 1966, by Mr. Karl Yordy, then Assistant Director, The Division of Regional Medical Programs, discussed

the question of the bonding with Grants Management. Their conclusion was that the insurance company would try to recover its losses from the organization or individual who was covered by the bond; however, it was their opinion that in this case the insurance company would have to move against the corporation rather than individual members of the Board of Directors.

Unfortunately at this point in time, the government was only beginning its relationship with what it later termed "Financially Dependent Organizations". These are organizations that have relatively no money of their own and are almost entirely dependent upon Federal funds for their support. In fact, the manual for financially dependent organizations was not developed by the Controller of HEW until June of 1970. CCRMP was one of the earliest RMP organizations of this type and few knew how to proceed with the appropriate financial assurances. Since that time CCRMP itself has developed several of these organizations, including the Drew School which is now a multimillion dollar operation. Undoubtedly we will develop more. But at that point in 1966 the rules of the game were indefinite.

On October 24, 1966, Mr. Robert Lindee, Assistant Dean at Stanford Medical School and acting for the Chairman of CCRMP, Dean Robert Glaser, went to the Division of Regional Medical Programs to discuss this matter. According to a memo for the record by Karl Yordy with whom this discussion took place, the conversation covered the following matters:

"Mr. Robert Lindee, Assistant Dean at Stanford Medical School, came to my office to discuss the problems which had been encountered by the California Coordinating Committee in obtaining the performance bond. As reported to me by Dr. Borhani, the insurance agent in San Francisco,

who had obtained the bond, did indicate to the group that each of the officers of the corporation who signed the bond could be held financially responsible as individuals if the insurance company was required to pay the Federal government because of an audit disallowance. This requirement was unacceptable to the members of the corporation; and as a result, their signatures were withdrawn from the bond because this requirement for the bond seemed to be different than the bond obtained by the Wisconsin Regional Medical Program, Inc., even though the insurance company involved was the same (The Northwestern National Insurance Company of Milwaukee). I called Dr. John Hirschboeck, Program Coordinator for the Wisconsin Regional Medical Program, Inc., to discuss his understanding of the requirements of their bond. Dr. Hirschboeck explained that they had originally contacted a bonding company in Baltimore which would have made the same requirement of personal financial responsibility. Finding this unacceptable, they contacted the Northwestern National Insurance Company and were able to procure the bond without this requirement because of the personal character and standing in the community of the officers of the corporation.

Dr. Hirschboeck then called me back after talking to their insurance agent and said that it was the Wisconsin Regional Medical Program, Inc. that was bonded and not the individual members of the corporation. The insurance agent also suggested that he saw no reason why the Northwestern National Insurance Company would not allow the same procedure with the California corporation if the character and standing of the incorporators in California was demonstrated. The agent also indicated that perhaps the insurance agent in San Francisco with whom the California group was dealing was being overly cautious."

When the attorneys for the California Medical Association, California Hospital Association, and the Universities discussed the possible way out of the dilemma of fiscal responsibility, the California Hospital Association and CMERF both were suggested as possible fiscal agents.

The term "fiscal agent" was used constantly throughout the discussions and in the various communications. The term "grantee" did not appear until such time as it became obvious that the proposal which had been submitted and approved would need a new "face sheet". There is perhaps a subtle distinction between a "fiscal agent" and a "grantee". And there was a lack of knowledge on the part of the Committee concerning the technical provisions of Section 903 of

the Regional Medical Program Law. It can be seen, though, from the written agreement between CCRMP and CMERF that the two organizations had a somewhat different concept of "grantee" than finally emerged within Regional Medical Programs Service.

In a letter dated October 27, 1966, to Dr. Marston as Chief of DRMP, Dr. Robert Glaser, Chairman of CCRMP, set forth the agreement that had been reached by the CCRMP and CMERF:

"Attached herewith is a revised FACE SHEET for the planning grant application from the State of California. The initial application showed the applicant organization as the California Committee on Regional Medical Programs, and we are now requesting that the California Medical Education and Research Foundation be substituted as the official applicant for and recipient of a planning grant under PL 89-239. Change in applicant is requested in order to meet administrative and financial requirements of an applicant receiving a grant under PL 89-239.

The change in applicant in no way changes the planning procedures as outlined in our initial application. Written assurance has been received by the California Committee that California Medical Education and Research Foundation will act solely in an administrative capacity and that policies heretofore or hereafter adopted by the California Committee will be governing, and subject only to California Medical Education and Research Foundation's primary commitment to administer and account for the funds in accordance with the law and applicable regulations and instructions of the Surgeon General.

The following statement of the policy has been agreed upon by the California Committee and California Medical Education and Research Foundation. The California Medical Education and Research Foundation, a non-profit, tax exempt education and research organization established in 1962 by the California Medical Association, and acting on behalf of the California Committee on Regional Medical Programs, will serve as the recipient and disbursing agent of planning grant funds received from the U.S. Public Health Service for the purpose of complying with the regulations under Public Law 89-239.

In assuming this responsibility, California Medical Education and Research Foundation will:

1. Comply with the specific provisions of Section 903 of the Public Health Service Act; and with

addition to ensure the successful performance

California Medical Education and Research Foundation has, for several years, demonstrated its fiscal responsibility by virtue of its past history of performance in receiving grants from Federal, state, and local agencies, and in accounting for the use of such monies following the completion of studies it has either undertaken or for which it has been responsible for supervising.

In assuming a similar responsibility, in serving in a fiscal and accounting capacity on behalf of the California Committee on Regional Medical Programs, the California Medical Education and Research Foundation will be guided by, and adhere to, the policy decisions of the California Committee on Regional Medical Programs (as adopted by the full Committee or the Executive Committee of that organization which may act on its behalf). In so doing, however, the California Medical Education and Research Foundation will exert only those veto powers which are in conformity with or required to adhere to Title IX of the Public Health Service Act, but will in no manner make unilateral decisions which are at variance with the goals and objectives of the California Committee on Regional Medical Programs as contained in its planning grant application, or with the conditions of performance established by the California Committee on Regional Medical Programs and its Advisory Committee."

On October 28, 1966, the Board of Directors of CMERF met. One of the matters on its agenda was CMERF's fiscal role on behalf of CCRMP. The Board of Directors took under consideration a copy of the letter quoted above which Dr. Glaser had written to Dr. Marston. The minutes of that meeting read as follows:

"Doctor MacLaggan provided the background regarding the Committee's formation and its efforts to secure a planning grant from the National Institutes of Health. He reported that one of the obstacles to the actual receipt of the monies was the absence of an agency which would be responsible for the fiscal and accountability responsibilities which P.L. 89-239 and the National Advisory Council required. The capabilities of CMERF had therefore been offered and accepted by the California Committee. Mr. Hassard explained the conditions under which CMERF could assume this fiscal role. The conditions cited were unanimously approved by the Board. Mr. Hassard then read the letter addressed by Dean Robert J. Glaser to Doctor Robert Q. Marston in which these conditions were offered as a basis for designating CMERF as the responsible fiscal agency to serve on behalf of the California Committee. The Board unanimously approved of the conditions set forth in Doctor Glaser's letter of October 27 which would revise the planning grant application originally submitted by the California Committee on Regional Medical Programs, and then authorized Mr. Hassard to sign the revised application Face Sheet."

The following day a new face sheet was prepared and signed by Mr. Hassard. The face sheet was added to the project proposal as it was originally prepared and submitted by the National Advisory Council when CCRMP was to be the grantee.

There were no changes or amendments made except for the face sheet.

On November 10, 1966, Mr. Hassard then received notification of approval of the planning grant application as submitted by the California Medical Education and Research Foundation in the amount of \$223,400. On the same day, however, a letter was addressed to Dr. Nemat Borhani from the Chief, Development and Assistance Branch, Division of Regional Medical Programs, indicating that DRMP had "concern that the applicant organization, the California Medical Education and Research Foundation, cannot be considered to have the experience in handling large and numerous Federal grants and subcontracts nor the financial resources which would be essential if it were to serve as the grantee organization for multiple large supplementary or operational grants". The letter then went on to suggest that California should arrange to adopt a plan comparable to that being contemplated for Texas at that time where one of the universities would serve as the grantee. This letter again threw the RMP Program in California into consternation but it did raise the point that Texas was developing agreements among institutions where the grantee was protected in the event that any one of the participating institutions misspent or mismanaged any of the funds. These agreements, in essence, made the institutions misspending the funds nominal responsible for the exception in place of the grantee. No one knew the validity of these agreements, but most assumed that they could be made to work.

The above letter of November 10 was followed almost immediately by another letter from Dr. Marston indicating in effect that CCRMP should ignore the previous letter. Dr. Marston stated that "Though we suggested the possibility of those in California adopting an arrangement similar to that in Texas, you should not feel bound

by this suggestion in any way."

Dr. Marston indicated that if the California Medical Education and Research Foundation gave evidence of the existence of legally binding agreements with other institutions or agencies within the region assuring that the participating institutions would expend funds only in accordance with an approved budget and would be required to reimburse CMERF for any funds which might be subsequently disallowed, then the arrangement would be satisfactory. This position was ultimately accepted by CCRMP and the award that had already been made was accepted.

The check for the first portion of the funding had arrived and had been deposited in a newly created account under CMERF's name (known as CMERF II) but devoted solely to the operation of CCRMP, Inc. On February 24, 1967, the Board of Directors of CMERF met to confirm certain interim actions taken in regard to CCRMP by CMERF. The minutes indicate that the Board took the following actions:

"CONFIRMATION OF APPOINTMENT OF PAUL WARD AS EXECUTIVE DIRECTOR OF CCRMP

The Board confirmed, by unanimous vote, the appointment of Paul Ward as Executive Director of the California Committee on Regional Medical Programs; such appointment effective as of January 1, 1967, the date on which Mr. Ward was employed by the California Medical Education and Research Foundation.

RELATIONSHIP OF CMERF TO CCRMP

The Board reviewed the circumstances surrounding the CMERF application for planning grant funds for regional medical programs under P.L. 89-239. It reiterated the facts that: CMERF is the legal grantee of such funds; that the 28-member advisory committee which is designated as the California Committee on Regional Medical Programs (CCRMP) is, in fact, the advisory committee to CMERF for the planning grant application which has previously been received, as well as for grant requests still pending; that the Executive Committee on the CCRMP could logically serve as the operating committee for CCRMP and that at least one officer

FINANCIAL STRUCTURE AND ACCOUNTABILITY OF REGIONAL MEDICAL PROGRAM FUNDS

Mr. Hassard informed the Board of the bookkeeping system which had been developed. The system is so designed as to maintain separate bank accounts and records for the receipts and expenditures of each of the organizations and institutions involved in carrying out planning programs. Thus, CMERF itself has been designed as CMERF 1. The initial grant received on behalf of the statewide planning staff, of which Paul Ward is Executive Director, is CMERF 2. The funds to be received in the future will similarly be designated numerically for each of the medical schools, CHA, and CMA. The Board approved of the system which has been developed."

Thus, the CMERF Board has honored its part of the above agreement. It established a bank account (CMERF-2), devoted solely to CCRMP purposes which has been administered according to "the policy decisions of the CCRMP." CMERF has exercised no veto powers and has made no "unilateral decisions which are at variance with the goals and objectives of CCRMP". Although CMA and its local societies have at times taken positions which might be interpreted as limiting the scope of RMP, these positions have not been enforced through the CMERF fiscal mechanism but instead have been presented for debate and decision by the full CCRMP Regional Advisory Group. The executive Committee of CCRMP has served as the operating committee making most fiscal decisions not deemed proper to refer to the full CCRMP. On the other side of the agreement CMERF has "in serving in a fiscal and accounting capacity on behalf of CCRMP" caused periodic audits to be made and accounting practices to be reviewed by their retained audit firm, John F. Forbes and Co. This firm has acted both as auditors of accounts and advisors on accounting practices. In summation, generally the terms of the original agreement which was approved by DRMP have been complied with and to date there has been no need or request to modify the arrangement. We would suggest that the phrase "retains the power to overrule" goes beyond the facts of the situation in view of the history and the written agreement.

Turning now to the recommendations which appeared in Draft Finding No. 1, you have recommended that we expand the current requirement for Area Office budgeting by functional categories on the RMP Form 8, to include budget data for (a) developing project proposal and (b) monitoring the execution of approved projects. Your second recommendation is that we require Area Offices to account for and report actual costs by the functional categories established in the core budgets and explain any significant deviations from the budget.

From the point of view of sound and effective management, no one could argue with the value of these recommendations. As program managers, we are also in general agreement with the substance of the draft critique leading up to these recommendations and in fact have taken steps to respond to the "PROGRAM FOR IMPROVING THE QUALITY OF GRANTEE MANAGEMENT" published by the Controllers of DHEW on June 1970. We do believe, however, that it is necessary to consider both the history of the development of the California RMP program and the fact that the program has been engaged in a far wider spectrum of activities at the Area level than is indicated in the body of the Draft. Many of these activities lend themselves to a structured planning and budgeting system while others have defied the best thinking of institutional and Federal management experts. Because of the philosophy advanced in the early stages of the program and the program's history of development, we, as managers, have been constantly made aware that our management policies and procedures should not stifle initiative and innovation or produce an institution that is so rigid that it would be unable to respond to the unusual dictates and objectives of the program.

of the program made unusual efforts to indicate that program direction would not come from the top but instead ideas should emerge from the lowest grass-root level possible and filtrate upward for funding and support. The fact that only very general guidelines were published about the program and virtually no regulations were issued indicates the extreme attempts that were made by DHEW to see that the program operated from the bottom up and not from the top down.

The Guidelines were filled with such vague statements as this effort "calls for the development of Regional Medical Programs which create an effective environment for continuing adaptation, innovation, and modification", and "The Regional Medical Programs present the medical interest within a region with an instrument of synthesis that can capitalize on and reinforce the various trends and resources," and "It is the interaction of these trends at this time, rather than an abstract conceptualization, which not only justifies but requires a synthesizing force such as the Regional Medical Programs" and "Among various identified needs, there also are often relationships which, when perceived, offer even greater opportunities for solutions." "The danger of project visualization, which is akin to tunnel vision, must be guarded against." The above sentences in the Guidelines indicate the vagueness with which the program was begun. Yet this was deliberate in order to assure that the program would avoid direction from above and attempt to capitalize to the greatest degree possible on actions and concepts that would emanate from the lowest possible level within the health care system. This may have been highly idealistic and impractical, but it was a deliberate attempt to determine whether or not progress could be made in this fashion and thereby avoid directives and regimentation from the top down.

At this point in time that philosophy may seem rather far afield from the question of budgeting and accounting procedures. It did permeate all aspects of the program however, and as people in institutions become involved in the program, essentially from a voluntary point of view, they jealously guarded that concept in all of the various areas of operation, including fiscal management.

The development of the California region involved other facts and conditions that tended to emphasize this philosophy. As indicated earlier in this letter, several university medical centers were involved in forming what eventually became CCRMP, Inc. Some of these medical centers had developed planning grant applications in 1965 and submitted them to NIH for funding during the time when the combined group was developing theirs. As a result of the 1965 site visit, they were obligated to withdraw these planning grant applications and join with CCRMP, Inc. in the planning process. As the record indicates, the first site visit decided that California would be one region for planning. Although a later site visit team and the National Advisory Council decided that California would also be a region for operations, at the time of the first planning grant some of the university medical centers believed that they would have their own region when they entered the operational stage. The fact that California was made a region for operational purposes was accepted with some reluctance by the centers concerned. There was a continuous struggle for local autonomy in all aspects of the program and subsequent site visit teams gave de facto recognition to the local autonomy. Although there was never any question raised by the site visit teams or by the National Advisory Council concerning California's status as a region, recognition for local autonomy was given in the way the site visits were structured. When site visit teams came to California at later dates, not only did they review the region as a whole, but

they also scheduled individual and separate visits with the areas concerned.

As management we anticipated the need for better budgetary and expenditure controls, although we felt that we had little authority upon which to proceed. Prior to the publication by DHEW in June 1970 of its manual for "Financially Dependent Organizations," our Region Office spent a considerable period of time exploring the possible implementation of program budgeting. It was discussed with the areas and it was discussed with the fiscal people at the university level. The concept was eventually abandoned, however, with the advent of the new RMPS forms for reporting and the deliberations of the FAST TASK Report. We believed that we were meeting the requirements of the program by converting to the new forms, and we further believed that a further tightening of the system was not feasible at that time.

We would make two general comments about the implications of the Draft Report. The first is that it lists five basic functions of each Area Office. We believe that this is a rather narrowly drawn definition of Area Office functions and might lead to the conclusion that the development and management of funded projects is an adequate measure of the Area Office's success or failure. We believe that this conclusion would be erroneous and extremely unfortunate if left to stand as valid. Project development and management is but one product of the activities intended to be the function of RMP. Other activities, such as establishing regional cooperative relationships, the acts of providing information and resources to providers that could not otherwise be obtained by them, and the acts of keeping discussions going about the health needs and providing suggestions as to how they might be resolved certainly are as important as project development itself. These latter acts, while possible

of describing and listing, often defy cost analysis simply because no one can estimate the value of their final result. In addition, any listing of the functions of an Area Office would have to be considered a perpetually changing list. To illustrate but one example, functions 1 and 2 listed in the Draft indicate that the Areas are identifying the health care needs and assessing medical resources in the Area. To be sure, we have been doing this to the extent that we have found it necessary, but essentially this should be the function of Comprehensive Health Planning. To the degree that CHP is able to perform its functions in these two areas, RMP can then abandon its efforts. Certainly we should be phasing out of these two activities as CHP becomes more sophisticated and able to accomplish its own objectives. We would then respond to the needs and resources as indicated in the CHP determinations.

The second implication is that projects are developed which are of measurable magnitude and that, in essence, the program staff in the Area is the sole source and developer of the proposal. It is difficult for us to determine how the cost figure cited in the Draft was determined, but it creates a completely erroneous concept of what is being done. Some projects are developed in their totality by the Area Staff, but in keeping with the original philosophy of the program, many projects are developed by groups outside of the Area Office and are submitted to them for some degree of assistance in their final preparation. These projects are then reviewed at the Area level by the Area Advisory Group to determine their appropriateness to meet Area needs as well as the appropriateness of the manner in which the project proposes to meet the needs. This manner of program development follows from RMP's NIH heritage. It will be recalled that independent groups, usually in universities and

medical centers, develop proposals and submit them to NIH for funding. One of the major additions of the RMP program was that there was to be in existence a paid staff to help the community develop proposals to submit for funding. It would be erroneous if we assume that all NIH proposals are prepared by unpaid interested parties, since many NIH proposals are prepared by persons borrowed from other NIH funded projects. But the RMO approach was to be a more honest and direct approach. We were to provide paid staff to help the community develop a proposal to do what it believed needed to be done. P

Another aspect that has to be emphasized is that the Area Staff prepares projects not only for RMP funding but also for a wide variety of other funding sources. Although on first glance this might seem to be a distortion of RMP purposes, it nevertheless has been incorporated into the normal routine of the program. Projects funded from other sources reach into several millions of dollars, including emergency medical services projects that were funded from other sources, Area Health Education Center projects which are about to be funded by the Bureau of Health Manpower, and several other types of projects aimed at NIH funding. In addition, there is always an element of gambling present in attempting to meet the health needs of the community. In each fiscal year there are always earmarked funds. Those who are able to correctly anticipate these earmarkings can begin the development of proposals early enough to assure funding. If you begin proposals early, however, and the earmarkings failed to materialize, then sometimes you have gambled in vain. Last year funds were earmarked for Emergency Medical Services, Area Health Education Centers, Kidney Disease, among others. Per-
 that anticipated these earmarkings usually had an advantage.

for adoption.

In short, we wish to state that we are more than willing to recommend to CCRMP that we should move in the direction indicated by the recommendations, and state further that some progress has already been made toward this end. Our problem with the draft statement is the narrow definition of area office function and the assumption that functional budgeting and cost accounting would greatly change the production pattern of the program.

Progress which has been made includes the formation of a Program Review Committee of the Regional Advisory Group which reviews program and fiscal reports three times per year. A fiscal management information system provides data based on expenditure reports from the area offices on a monthly basis. Our Regional Evaluators Committee is currently considering methods of structuring and streamlining fiscal and program reporting and is developing an improved instrument to replace our current reporting form.

We continue to believe that the development of effective planning, budgeting and reporting systems must involve our area offices and must take into account their needs and resources. As a result, we have undertaken the development of a rational system that assumes the necessity of placing useful information in the hands of responsible managers at all levels.

Very truly yours,